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# New Solutions in Service Design and Delivery are Necessary to Combat Disease Burden

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EDITORIAL

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IN THIS ISSUE of the *Journal*, Jindal and colleagues compellingly document the high disease burden for asthma and chronic bronchitis in India.[1] With a comprehensive survey of 169 575 individuals from 23 sites across 12 centres, they estimate that one or more respiratory symptoms were present in 8.5% of individuals. The national burden of asthma and chronic bronchitis is estimated at 17.23 million and 14.84 million, respectively. In absolute terms, these are not small numbers. The unfortunate reality, however, is that the brunt of this disease burden is likely disproportionately borne by the economically impoverished and the socially disenfranchised. The authors suggest that most of the risk factors are preventable, yet public health efforts to combat disease burden have had limited success. Perhaps current health care remains a service delivery challenge in terms of access to both reasonable care and medication. Alternatively, it highlights the inadequate level of investment in public health to improve prevention. Nevertheless, a compelling case now exists for considering a systemic redesign of health care delivery and integrating public health efforts in more innovative ways.

In the management literature, there is a focus on inclusive innovation,[2] i.e., the development and implementation of new ideas which aspire to create opportunities that enhance social and economic well-being for disenfranchised members of society. There are three processes that are fundamental for such innovation: 1) reframing constraints, 2) enacting new business models and 3) bridging access. 'Reframing constraints' refers to organisational actions that take context as an assumed input and find new ways to perceive these constraints to create opportunities. Reframing constraints thus includes processes that diagnose constraints to inspire and articulate creative, local solutions. 'Enacting new models' refers to establishing completely new system design, structures, and processes that enact or implement solutions to achieve inclusive growth. Here, enacting new models refers to fundamental re-conceptualisations of organisational design and business models. 'Bridging access' refers to health system processes that identify, locate and create access to disenfranchised individuals and communities. In so doing, bridging access involves implementing new forms of partnerships and networks that connect hitherto disconnected individuals with opportunities.

All three conditions are necessary, but not individually sufficient, to support inclusive innovation. If we combined these three processes, perhaps a completely different perspective of how to tackle the high disease burden could be revealed. Perhaps innovation is a seamless integration of public health and health care delivery at the point of care. Perhaps redesign is about data collection, transparency and accountability for health care outcomes. Conceivably, new business models would require countries, districts and health care centres to be accountable, such that their funding is closely tied to measurable progress. New incentives may be needed to forge partnerships across public and private hospitals, and act as a carrot for innovative localised solutions. Whatever the form of innovation, one thing is clear: we need innovative ideas to solve traditional problems. Otherwise we can expect these numbers reported by Jindal and colleagues to only rise, and not abate.

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2 George G, McGahan A M, Prabhu J. Innovation for inclusive growth: towards a theoretical framework and a research agenda. J Management Studies 2012; 49: 661–683.